Tidal Neuropsychology, PLLC
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____, _____
(print full name) (date of birth)

hereby authorize the release of my health information from Griffin Pollock Sutton, Ph.D., ABN, Tidal Neuropsychology PLLC, 19 South Hampstead Village Drive, 19 South Hampstead Village Drive, Hampstead, North Carolina, 28443 to the following recipient(s):

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

(Please use additional form for additional recipients.)

Purpose of disclosure: (If you are a registered patient and do not wish to specify a specific purpose, please write "at the request of the individual for coordination of care.")

_____

Information requested: _____

_____

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information. Substance abuse information is protected per the confidentiality and disclosure requirements of 42 CFR Part 2. HIV/AIDS information is protected per the confidentiality and disclosure requirements under G.S. 130A-143.

I give my permission for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire 365 days after the date signed. The requestor should not redisclose any medical record to another party without further written consent.

I will not hold Griffin Pollock Sutton, Ph.D., ABN nor Tidal Neuropsychology PLLC liable for any injury, whether mental or physical, resulting from any misunderstanding of information in the released report as a result of my not asking Dr. Sutton for clarification of the information therein.

_____ _____
Signature of Patient/Legal Representative Date

_____ _____
Signature of Witness Date